CONFIDENTIAL COMMUNICATION REQUEST

Purpose: This form is used for an individual's request that we use alternative means or an alternative location when communicating about health information to avoid endangering the individual.

Please type or print neatly; we are not able to process incomplete or illegible forms.

MDH PROGRAM NAME: _____

Section A: Individual requesting confidential communication.

Last Name:_____First Name:_____MI: _____
Street Address: _____Apt#: _____
City:_____State:_____Zip: _____
Phone: (home)_____(work)_____Date of Birth: ____/____/____

Section B: To the Individual – Please read the following and complete the information requested.

You have the right to request that we communicate about all or part of your health information by alternative means or to an alternate location to avoid endangering you. We will accommodate your request if: (1) it is reasonable and (2) you provide reasonable alternative means or alternate location for communicating with you. We will not investigate the validity of any claim that failure to communicate with you by the alternative means or at the alternate location could endanger you.

The information requested below is required. If you submit an incomplete or illegible request, we will not be able to process it immediately. To avoid a delay in processing, please do not skip any of the following:

Please describe the health information you want to make subject to confidential communication (i.e., all information, billing information, only claim information for a specific diagnosis, etc.):

Please explain how any applicable payment will be handled:

Please check one of the boxes and complete that section.

☐ You request that we communicate with you about your health information by following alternative means (provide full information on the alternative means you want us to use):

☐ You request that we communicate with you about your health information at the following alternate location (provide full information on the alternate location):

INDIVIDUAL'S SIGNATURE

Signature:_____Date: _____

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

LETTERHEAD)

ACCOMMODATION OF CONFIDENTIAL COMMUNICATION REQUEST

(DATE)

(INDIVIDUAL'S NAME)
(ALTERNATIVE LOCATION ADDRESS)

Dear (INDIVIDUAL):

This letter confirms that we will accommodate your request that we communicate with you about your health information by the alternative means or at the alternate location you requested. We will continue to use the alternative means or alternate location that you requested until we receive further notice from you. Accordingly, please keep us informed if your needs change.

If you have questions, please contact the undersigned.

Sincerely,

By: _____

(LETTERHEAD)

DENIAL OF CONFIDENTIAL COMMUNICATION REQUEST

(DATE)

(INDIVIDUAL'S NAME)
(ALTERNATIVE LOCATION ADDRESS):

Dear (INDIVIDUAL):

We are not able to accommodate your ____/____/____ request that we communicate about your health information by the alternative means or at the alternate location you requested.

☐ We need the following additional information before we can accommodate your request:

☐ We were not able to process your form requesting confidentiality because it was incomplete or illegible. Another copy is attached for your convenience. Please type or print neatly and fill in all blanks.

Until we have the additional information, or a complete, legible form, we will communicate with you about your health information as follows:

Please contact me, if you have questions, or want to discuss further your desire that we communicate confidentially with you.

Sincerely,

By: _____Contact Telephone number: _____

(LETTERHEAD)

NOTIFICATION OF CONFIDENTIAL COMMUNICATION REQUIREMENT

To: _____

On ____/____/____, the individual below requested that we communicate with them about their health information by alternative means or at an alternate location. We are required to accommodate this request. Until further notice from us, you must adhere to the following when communicating about health information with this individual:

Health information subject to the individual's confidential communication request:

☐ All communications about the above health information must be provided to the individual by the following means:

☐ All communications about the above health information must be sent to the following location:

If you have questions, please contact the undersigned.

Sincerely,

By: _____Date: _____

Individual Requesting Confidential Communications:

Last Name:_____First Name: _____

Street Address: _____Apt #: _____

City: _____State:_____Zip: _____

Phone: (home)_____(work) _____

Date of Birth: ____/____/____